



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Houston Orthopedic Surgical

Respondent Name

Houston ISD

MFDR Tracking Number

M4-16-0758-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

November 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please provide claim status for this PT, see the attached letter and claim. We have not received any remits for this date of service."

Amount in Dispute: \$5,925.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We escalated this review to our bill review vendor and have issued payment to the provider in the amount \$5,534.36 based on fee guidelines along with interest owed in the amount of \$89.47."

Response Submitted by: Cannon Cochran Management Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 8, 2015	Outpatient Hospital Services	\$5,925.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 170 – Reimbursement is based on the outpatient/inpatient fee schedule.

- 799 – Allowance has been adjusted in accordance with OPPS schedule allowance.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403(f) states,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 27658 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0049, which, per OPPS Addendum A, has a payment rate of \$1,660.83. This amount multiplied by 60% yields an unadjusted labor-related amount of \$996.50. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$964.51. The non-labor related portion is 40% of the APC rate or \$664.33. The sum of the labor and non-labor related amounts is \$1,628.84. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$814.42. This amount multiplied by 200% yields a MAR of \$1,628.84.
- Procedure code 28118 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0055, which, per OPPS Addendum A, has a payment rate of \$1,743.52. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,046.11. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$1,012.53. The non-labor related portion is 40% of the APC rate or \$697.41. The sum of the labor and non-labor related amounts is \$1,709.94. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$1,709.94. This amount multiplied by 200% yields a MAR of \$3,419.88.

- Procedure code 64450 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0206, which, per OPPS Addendum A, has a payment rate of \$372.76. This amount multiplied by 60% yields an unadjusted labor-related amount of \$223.66. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$216.48. The non-labor related portion is 40% of the APC rate or \$149.10. The sum of the labor and non-labor related amounts is \$365.58. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,775. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$182.79. This amount multiplied by 200% yields a MAR of \$365.58.
 - Procedure code 97001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The Medicare rate for this code for 2015 is \$76.38. This amount divided by the Medicare conversion factor of 35.7547 and multiplied by the Division conversion factor of 56.2 yields a MAR of \$120.06
2. The total allowable reimbursement for the services in dispute is \$5,534.36. This amount less the amount previously paid by the insurance carrier of \$5,534.36 leaves an amount due to the requestor of \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February , 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.